Adventist Risk Management, Inc.

EMPLOYEE HEALTH CARE
ENROLLMENT APPLICATION

Employee Instructions: Complete the entire application **except the employer section of this page**. Return your completed application within five days to your employer. Benefits will be withheld until application is received.

EMPLOYEE INFORMATION:

Group # :	**Dept # :**	Employer:		Employee's E-Mail Address:
SSN:		First Name:	MI	Last Name:
Address 1				Department:
Address 2				Work Phone:
City	State	Zip		Home Phone:

Sex	Birthdate	Marital Status	Hire Date	Effective Date	Previous Employer
☐ Male ☐ Female	(MM/DD/YYYY)	☐ Married ☐ Single	(MM/ DD/YYYY)	(MM/DD/YYYY)	

SPOUSE INFORMATION:

Spouse First Name:	M.I.	Spouse Last Name:	

Spouse's Birthdate (MM/DD/YYYY)	Spouse's SSN:	Is Spouse Employed: ☐ Yes ☐ No	Spouse's Employer: Name	Phone #

Other Insurance: ☐ Yes ☐ No	Dependents Covered: ☐ Yes ☐ No	Name of Insurance:

Policy Holder ID Number	Effective Date

DEPENDENT INFORMATION:

Relationship	First Name	MI	Last Name	Birthdate (MM/DD/YYYY)	Other INS (Y/N)	Other INS Prim/Sec	Dependent's SSN
☐ Son ☐ Daughter							
☐ Son ☐ Daughter							
☐ Son ☐ Daughter							
☐ Son ☐ Daughter							

EMPLOYER INSTRUCTIONS TO BENEFIT PLAN ADMINISTRATOR:

OFFICE USE ONLY

Name	Effective Date	Primary/Secondary Medical	Dental	Vision	Rx
Employee					
Spouse					
Dependent Children 1.					
2.					
3.					
4.					

Received On:

	DATE COMPLETED
IBC	
TRANS#	
CARD	□IBC □ARM
VERIFIED	□IBC □AHA □DE □RX
HIPAA	

FOR ARM OFFICE USE

OFFICE USE ONLY

Comments:

Employer Signature: _____
Signatory's Title: _____ Date: _____ Coverage Code _____

Revised 2011-08

NORTH AMERICAN DIVISION HEATLH CARE ASSISTANCE PLAN
FOR EMPLOYEES OF SEVENTH-DAY ADENTIST ORGANIZATIONS

Plan Coverage Selection

Policy Type	**Plan Covers**	**Plan Description**	**Employee**	**Spouse**	**Dependent**
N	Employee Only	Coverage for employee only.	X	-	-
S	Employee + Spouse	Coverage for employee and spouse.	X	X	-
C	Employee & Child(ren)	Coverage for employee and child(ren).	X	-	X
F	Family	Coverage for employee, spouse, and child(ren).	X	X	X

EMPLOYEE AUTHORIZATION AND CERTIFICATION

I authorize all providers of health care to furnish all records pertaining to medical history, services and rendered treatment given as pertains to evaluation of enrollment application and/or claims. This authorization will become effective immediately and will remain in effect as long as necessary to enable Adventist Risk Management Inc to process the application and/or claims.

I agree to notify my employer of any changes in family status or eligibility of family members. Failure to notify my employer of any status changes will authorize my employer to ask Adventist Risk Management Inc to deny payments of future claims and ask for collection of past paid claims for ineligible spouse or dependents.

I certify that all of the above information is complete and correct.

Employee Signature

Date Signed